

occur, and how is the maximum coverage period measured?

Q-3: If an employee fails to pay the employee portion of premiums for coverage under a group health plan during FMLA leave or declines coverage under a group health plan during FMLA leave, does this affect the determination of whether or when the employee has experienced a qualifying event?

Q-4: Is the application of the rules in Q&A-1 through Q&A-3 of this section affected by a requirement of state or local law to provide a period of coverage longer than that required under FMLA?

Q-5: May COBRA continuation coverage be conditioned upon reimbursement of the premiums paid by the employer for coverage under a group health plan during FMLA leave?

[T.D. 8812, 64 FR 5173, Feb. 3, 1999, as amended by T.D. 8928, 66 FR 1848, Jan. 10, 2001; T.D. 9457, 74 FR 45997, Sept. 8, 2009]

§ 54.4980B-1 COBRA in general.

The COBRA continuation coverage requirements are described in general in the following questions-and-answers:

Q-1: What are the health care continuation coverage requirements contained in section 4980B of the Internal Revenue Code and in ERISA?

A-1: (a) Section 4980B provides generally that a group health plan must offer each qualified beneficiary who would otherwise lose coverage under the plan as a result of a qualifying event an opportunity to elect, within the election period, continuation coverage under the plan. The continuation coverage requirements were added to section 162 by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272 (100 Stat. 222), and moved to section 4980B by the Technical and Miscellaneous Revenue Act of 1988, Public Law 100-647 (102 Stat. 3342). Continuation coverage required under section 4980B is referred to in §§ 54.4980B-1 through 54.4980B-10 as COBRA continuation coverage.

(b) COBRA also added parallel continuation coverage requirements to Part 6 of Subtitle B of title I of the Employee Retirement Income Security Act of 1974 (ERISA) (29 U.S.C. 1161-1168), which is administered by the U.S. Department of Labor. If a plan does not comply with the COBRA continuation coverage requirements, the Internal Revenue Code imposes an excise tax on

the employer maintaining the plan (or on the plan itself), whereas ERISA gives certain parties—including qualified beneficiaries who are participants or beneficiaries within the meaning of title I of ERISA, as well as the Department of Labor—the right to file a lawsuit to redress the noncompliance. The rules in §§ 54.4980B-1 through 54.4980B-10 apply for purposes of section 4980B and generally also for purposes of the COBRA continuation coverage requirements in title I of ERISA. However, certain provisions of the COBRA continuation coverage requirements (such as the definitions of group health plan, employee, and employer) are not identical in the Internal Revenue Code and title I of ERISA. In those cases in which the statutory language is not identical, the rules in §§ 54.4980B-1 through 54.4980B-10 nonetheless apply to the COBRA continuation coverage requirements of title I of ERISA, except to the extent those rules are inconsistent with the statutory language of title I of ERISA.

(c) A group health plan that is subject to section 4980B (or the parallel provisions under ERISA) is referred to as being subject to COBRA. (See Q&A-4 of § 54.4980B-2). A qualified beneficiary can be required to pay for COBRA continuation coverage. The term *qualified beneficiary* is defined in Q&A-1 of § 54.4980B-3. The term *qualifying event* is defined in Q&A-1 of § 54.4980B-4. COBRA continuation coverage is described in § 54.4980B-5. The election procedures are described in § 54.4980B-6. Duration of COBRA continuation coverage is addressed in § 54.4980B-7, and payment for COBRA continuation coverage is addressed in § 54.4980B-8. Section 54.4980B-9 contains special rules for how COBRA applies in connection with business reorganizations and employer withdrawals from a multiemployer plan, and § 54.4980B-10 addresses how COBRA applies for individuals who take leave under the Family and Medical Leave Act of 1993. Unless the context indicates otherwise, any reference in §§ 54.4980B-1 through 54.4980B-10 to COBRA refers to section 4980B (as amended) and to the parallel provisions of ERISA.

Q-2: What standard applies for topics not addressed in §§ 54.4980B-1 through 54.4980B-10?

A-2: For purposes of section 4980B, for topics relating to the COBRA continuation coverage requirements of section 4980B that are not addressed in §§ 54.4980B-1 through 54.4980B-10 (such as methods for calculating the applicable premium), plans and employers must operate in good faith compliance with a reasonable interpretation of the statutory requirements in section 4980B.

[T.D. 8812, 64 FR 5173, Feb. 3, 1999; 64 FR 14382, Mar. 25, 1999, as amended by T.D. 8928, 66 FR 1849, Jan. 10, 2001]

§ 54.4980B-2 Plans that must comply.

The following questions-and-answers apply in determining which plans must comply with the COBRA continuation coverage requirements:

Q-1: For purposes of section 4980B, what is a group health plan?

A-1: (a) For purposes of section 4980B, a group health plan is a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer or employee organization or to their families. Individuals who have an employment-related connection to the employer or employee organization consist of employees, former employees, the employer, and others associated or formerly associated with the employer or employee organization in a business relationship (including members of a union who are not currently employees). Health care is provided under a plan whether provided directly or through insurance, reimbursement, or otherwise, and whether or not provided through an on-site facility (except as set forth in paragraph (d) of this Q&A-1), or through a cafeteria plan (as defined in section 125) or other flexible benefit arrangement. (See paragraphs (b) through (e) in Q&A-8 of this section for rules regarding the application of the COBRA continuation coverage requirements to certain health flexible spending arrangements.) For purposes of this Q&A-1, insurance includes not only group insurance policies but also one or more individual insurance policies in any arrangement that involves

the provision of health care to two or more employees. A plan maintained by an employer or employee organization is any plan of, or contributed to (directly or indirectly) by, an employer or employee organization. Thus, a group health plan is maintained by an employer or employee organization even if the employer or employee organization does not contribute to it if coverage under the plan would not be available at the same cost to an individual but for the individual's employment-related connection to the employer or employee organization. These rules are further explained in paragraphs (b) through (d) of this Q&A-1. An exception for qualified long-term care services is set forth in paragraph (e) of this Q&A-1, and for medical savings accounts in paragraph (f) of this Q&A-1. See Q&A-6 of this section for rules to determine the number of group health plans that an employer or employee organization maintains.

(b) For purposes of §§ 54.4980B-1 through 54.4980B-10, *health care* has the same meaning as *medical care* under section 213(d). Thus, health care generally includes the diagnosis, cure, mitigation, treatment, or prevention of disease, and any other undertaking for the purpose of affecting any structure or function of the body. Health care also includes transportation primarily for and essential to health care as described in the preceding sentence. However, health care does not include anything that is merely beneficial to the general health of an individual, such as a vacation. Thus, if an employer or employee organization maintains a program that furthers general good health, but the program does not relate to the relief or alleviation of health or medical problems and is generally accessible to and used by employees without regard to their physical condition or state of health, that program is not considered a program that provides health care and so is not a group health plan. For example, if an employer maintains a spa, swimming pool, gymnasium, or other exercise/fitness program or facility that is normally accessible to and used by employees for reasons other than relief of health or medical problems, such a facility does not constitute a program